FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030551

Facility Name: Brightview Care Center

Address: 4538 North Beacon (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 275-7200 **Fax #** (773) 275-7543

HFS ID Number: 363408520001

Date of Initial License for Current Owners: 02/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Cary N. Drazner, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,423	332	2,774	32,529	8
9	SNF/PED					9
10	ICF	15,319	98	46	15,463	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,742	430	2,820	47,992	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.95%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/1986 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,615

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,856	31,966	4,856	233,678		233,678		233,678			1
2	Food Purchase		223,652		223,652	(13,761)	209,892	(20)	209,872			2
3	Housekeeping	233,653	39,257		272,910		272,910	1,104	274,014			3
4	Laundry	79,841	7,299		87,140		87,140		87,140			4
5	Heat and Other Utilities			164,356	164,356		164,356	2,848	167,204			5
6	Maintenance	27,286	18,805	71,878	117,969		117,969	3,729	121,698			6
7	Other (specify):*											7
8	TOTAL General Services	537,636	320,979	241,090	1,099,705	(13,761)	1,085,945	7,661	1,093,606			8
	B. Health Care and Programs											
9	Medical Director			17,100	17,100		17,100		17,100			9
10	Nursing and Medical Records	1,603,194	106,908	90,348	1,800,450		1,800,450		1,800,450			10
10a	Therapy	77,451	1,132	6,868	85,451		85,451		85,451			10a
11	Activities	74,909	4,015	1,955	80,879		80,879		80,879			11
12	Social Services	93,896			93,896		93,896		93,896			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,849,450	112,055	116,271	2,077,776		2,077,776		2,077,776			16
	C. General Administration											
17	Administrative	223,254		82,500	305,754		305,754	(17,677)	288,077			17
18	Directors Fees											18
19	Professional Services			286,910	286,910		286,910	(207,175)	79,735			19
20	Dues, Fees, Subscriptions & Promotions			77,400	77,400		77,400	(43,709)	33,691			20
21	Clerical & General Office Expenses	163,708	26,127	157,616	347,451		347,451	(109,711)	237,740			21
22	Employee Benefits & Payroll Taxes			433,792	433,792	13,761	447,553		447,553			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,381	3,381		3,381	210	3,591			24
25	Other Admin. Staff Transportation			1,980	1,980		1,980	42	2,022			25
26	Insurance-Prop.Liab.Malpractice			145,970	145,970		145,970	7,730	153,700			26
27	Other (specify):*							37,986	37,986			27
28	TOTAL General Administration	386,962	26,127	1,189,549	1,602,638	13,761	1,616,399	(332,304)	1,284,095			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,774,048	459,161	1,546,910	4,780,119		4,780,119	(324,643)	4,455,476			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brightview Care Center #0030551 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,928	36,928		36,928	153,429	190,357			30
31	Amortization of Pre-Op. & Org.							5,920	5,920			31
32	Interest			56,125	56,125		56,125	165,708	221,833			32
33	Real Estate Taxes							161,642	161,642			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			549,053	549,053		549,053	30,699	579,752			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,643	142,325	313,968		313,968		313,968			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	96,902			96,902		96,902	(96,902)				43
44	**TOTAL Special Cost Centers**	96,902	171,643	220,618	489,163		489,163	(96,902)	392,261			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,870,950	630,804	2,316,581	5,818,335		5,818,335	(390,846)	5,427,489			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,507)	30		9
10	Interest and Other Investment Income	(2,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(595)	21		18
19	Entertainment				19
20	Contributions	(9,897)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,615)	21		24
25	Fund Raising, Advertising and Promotional	(33,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,855)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(167,502)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (390,695)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(151)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (151)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (390,846)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (120)	21	1
2	Marketing Salaries	(96,902)	43	2
3	Theft and Loss	(145)	21	3
4	Building Co. - Professional Fees	(2,862)	19	4
5	Building Co. - Other Expense	(660)	21	5
6	COPE Dues	(1,833)	20	6
7	Capitalized R&M	(1,550)	06	7
8	Non-Allowable Prior Year Legal	(5,904)	19	8
9	Excess Salaries	(57,526)	21	9
10				10
11				11
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100				100
101	Total	(167,502)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(20)											(20)	2
3	Housekeeping			719	385								1,104	3
4	Laundry													4
5	Heat and Other Utilities			1,245	1,603								2,848	5
6	Maintenance	(1,550)		3,909	1,370								3,729	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,570)		5,873	3,358								7,661	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			54,389	542	(72,608)							(17,677)	17
18	Directors Fees													18
19	Professional Services	(8,766)	2,862	(202,130)	364	495							(207,175)	19
20	Fees, Subscriptions & Promotions	(45,722)		1,956	3	54							(43,709)	20
21	Clerical & General Office Expenses	(190,516)	660	79,910	73	162							(109,711)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			210									210	24
25	Other Admin. Staff Transportation			42									42	25
26	Insurance-Prop.Liab.Malpractice		6,897	684	149								7,730	26
27	Other (specify):*			37,229		757							37,986	27
28	**TOTAL General Administration**	(245,004)	10,419	(27,710)	1,131	(71,140)							(332,304)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(246,574)	10,419	(21,837)	4,489	(71,140)							(324,643)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Brightview Care Center** **#** **0030551** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(44,507)	192,616	5,001	241	78							153,429	30
31	Amortization of Pre-Op. & Org.		5,920										5,920	31
32	Interest	(2,712)	165,645	430	2,345								165,708	32
33	Real Estate Taxes		159,598		2,044								161,642	33
34	Rent-Facility & Grounds		(456,000)	10,499	(10,499)								(456,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(47,219)	67,779	15,930	(5,869)	78							30,699	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(96,902)											(96,902)	43
44	TOTAL Special Cost Centers	(96,902)											(96,902)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(390,695)	78,198	(5,907)	(1,380)	(71,062)							(390,846)	45

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Brightview Building Company		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 456,000	Brightview Building Company	100.00%	$	$ (456,000)	1
2	V	32	Interest Income/Expense	60,271	Brightview Building Company	100.00%	225,916	165,645	2
3	V	30	Depreciation		Brightview Building Company	100.00%	192,616	192,616	3
4	V	31	Amortization		Brightview Building Company	100.00%	5,920	5,920	4
5	V	33	Real Estate Tax		Brightview Building Company	100.00%	159,598	159,598	5
6	V	26	Insurance Expense		Brightview Building Company	100.00%	6,897	6,897	6
7	V	19	Professional Fees		Brightview Building Company	100.00%	2,862	2,862	7
8	V	21	Other Expense		Brightview Building Company	100.00%	660	660	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 516,271			$ 594,469	$ * 78,198	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 719	$ 719	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,245	1,245	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,909	3,909	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	54,389	54,389	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	358	358	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	1,956	1,956	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	79,910	79,910	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	210	210	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	42	42	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	684	684	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	37,229	37,229	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	5,001	5,001	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	430	430	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	10,499	10,499	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%			30
31	V	19	HOME OFFICE	202,488	MANAGCARE, INC.	100.00%		(202,488)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,488			$ 196,581	$ * (5,907)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 385	$ 385	15
16	V		5	UTILITIES		MAZEL MANAGEMENT		1,603	1,603	16
17	V		6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,370	1,370	17
18	V		7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V		17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		542	542	19
20	V		19	PROFESSIONAL FEES		MAZEL MANAGEMENT		364	364	20
21	V		20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		3	3	21
22	V		21	CLERICAL & GENERAL		MAZEL MANAGEMENT		73	73	22
23	V		26	INSURANCE		MAZEL MANAGEMENT		149	149	23
24	V		30	DEPRECIATION		MAZEL MANAGEMENT		241	241	24
25	V		31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V		32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,345	2,345	26
27	V		33	REAL ESTATE TAXES				2,044	2,044	27
28	V									28
29	V		34	RENT	10,499				(10,499)	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 10,499			$ 9,119	$ * (1,380)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 9,892	$ 9,892	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	495	495	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	54	54	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	162	162	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	757	757	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	78	78	20
21	V								21
22	V	17	MANAGEMENT FEES	82,500	INTERCARE, LTD. C/O MANAGCARE	100.00%		(82,500)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,500			$ 11,438	$ * (71,062)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Davis	Owner	Administrative	72.34%	See Attached	11.87	19.78%	Sal, Alloc Sal.	$ 24,892	17-1, 17-7	1
2	Moshe Davis	Administrator	Administrative		See Attached	37.38	66.75%	Salary	85,451	17-1	2
3	Yehoshua Davis	Operations	Administrative		See Attached	11.42	20.39%	Salary	33,470	17-1	3
4	Chasida Davis	Relative	Clerical		See Attached	4.09	20.45%	Alloc. Sal	3,665	21-7	4
5	Shoshana Braun	Relative	Clinical Support		See Attached	1.50	32.47%	Salary	1,125	10-1	5
6	Nesanel Davis	Relative	Administrative		None	40.00	100.00%	Salary	82,288	17-1	6
7	Moshe Wolf	Relative	Administrative		See Attached	11.46	20.46%	Alloc Sal, Fees	14,650	17-1	7
8	Stanley Klem	Owner	Administrative	2.13%	See Attached	9.00	20.45%	Alloc. Sal	25,782	17-1	8
9	Renee Wolf	Relative	Clerical		See Attached	8.19	20.48%	Alloc. Sal	3,346	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 274,669		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	234,501	5	$ 3,513	$	47,992	$ 719	1
2	5	UTILITIES	PATIENT DAYS	234,501	5	6,086		47,992	1,245	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	234,501	5	19,103		47,992	3,909	3
4	10	NURSING SALARIES	PATIENT DAYS	234,501	5			47,992		4
5	17	ADMINISTRATIVE	PATIENT DAYS	234,501	5	265,757	265,757	47,992	54,389	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	234,501	5	1,750		47,992	358	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	234,501	5	9,556		47,992	1,956	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	234,501	5	390,462	341,991	47,992	79,910	8
9	24	SEMINARS	PATIENT DAYS	234,501	5	1,028		47,992	210	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	234,501	5	205		47,992	42	10
11	26	INSURANCE	PATIENT DAYS	234,501	5	3,344		47,992	684	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	234,501	5	181,911		47,992	37,229	12
13	30	DEPRECIATION	PATIENT DAYS	234,501	5	24,435		47,992	5,001	13
14	32	INTEREST EXPENSE	PATIENT DAYS	234,501	5	2,099		47,992	430	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	234,501	5	51,300		47,992	10,499	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	234,501	5			47,992		16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 960,549	$ 607,748		$ 196,581	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	234,501	5	$ 1,881	$	47,992	$ 385	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	234,501	5	7,831		47,992	1,603	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	234,501	5	6,696		47,992	1,370	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	234,501	5			47,992		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	234,501	5	2,649		47,992	542	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	234,501	5	1,778		47,992	364	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	234,501	5	16		47,992	3	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	234,501	5	357		47,992	73	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	234,501	5	728		47,992	149	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	234,501	5	1,175		47,992	241	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	234,501	5			47,992		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	234,501	5	11,457		47,992	2,345	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	234,501	5	9,986		47,992	2,044	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 44,554	$		$ 9,119	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	7	$ 50,000	$ 50,000	12	$ 9,892	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	7	2,500		12	495	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	7	271		12	54	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	7	821		12	162	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	7	3,825		12	757	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	7	394		12	78	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 57,811	$ 50,000		$ 11,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$ 4,000,000	$ 4,000,000	2/1/07	Prime	$ 225,916	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				100,000			20,085	6
7	Brightview Building Co.	X		Working Capital							36,040	7
8	See Supplemental Schedule										2,775	8
9	TOTAL Facility Related						$ 4,000,000	$ 4,100,000			$ 284,816	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,712)	10
11	Interest Income - Bldg Co		X								(60,271)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (62,983)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 4,100,000			$ 221,833	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocate ManagCare		X				$	$			$ 430	8
9	Allocate Mazel Mgmt		X								2,345	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,775	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Brightview Care Center **#** 0030551 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 177,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 167,842	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,158)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 170,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 161,642	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	136,212	8
	2001	139,755	9
	2002	141,322	10
	2003	171,974	11
	2004	165,798	12

2005 Accrual - $165,797 x 1.03 = $170,800 (Rounded)

R/E Tax Allocated From Mazel Management - $2,044

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Long Term Care Property	$ 66,320.88	$ 66,320.88
2.	14-17-115-018-0000	Long Term Care Property	$ 64,606.00	$ 64,606.00
3.	14-17-115-030-0000	Long Term Care Property	$ 34,870.77	$ 34,870.77
4.	See Attached	Allocated - Mazel Management	$ 41,756.66	$ 1,959.22
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 207,554.31	$ 167,756.87

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 29,600
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 5,920
4. Dates Incurred: 01/27/2002

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20	175	175	10,284	9
10	Various			1987	4,719		20	236	236	4,368	10
11	Various			1988	2,895		20	145	145	2,584	11
12	Various			1989	67,265		20	3,272	3,272	56,136	12
13	Various			1991	22,384		20	1,120	1,120	14,239	13
14	Various			1992	17,019		20	143	143	14,466	14
15	Various			1993	44,200		20	2,211	2,211	27,497	15
16	Various			1994	63,594		20	3,181	3,181	36,654	16
17	Various			1995	7,105		20	356	356	3,763	17
18	Various			1996	37,640		20	1,882	1,882	18,449	18
19	Various			1997	17,411		20	871	871	7,039	19
20	Various			1998	49,850		20	2,497	2,497	18,337	20
21	Various			1999	215,484		20	10,777	10,777	70,709	21
22	Various			2000	47,834		20	2,392	2,392	13,112	22
23	Various			2001	35,034		20	2,167	2,167	9,870	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,748,844	186,935		96,742	(90,193)	1,826,399	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		54,827	918		2,373	1,455	43,320	68
69	Financial Statement Depreciation			16,026			(16,026)		69
70	TOTAL (lines 4 thru 69)		$ 3,446,411	$ 203,879		$ 130,540	$ (73,339)	$ 2,177,226	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,446,411	$ 203,879		$ 130,540	$ (73,339)	$ 2,177,226	1
2	Duct Install,Fire Damper	2002	1,975		20	198	198	708	2
3	Boiler Ignitor Safety Control	2002	1,125		20	113	113	441	3
4	Install New Detector Edge In Elevator	2002	2,100		20	105	105	385	4
5	Conrtol Panels	2002	5,525		20	553	553	1,796	5
6	Elevator Door Detector System	2002	2,679		20	134	134	435	6
7	Hot Water Heater Coil	2002	1,422		20	119	119	365	7
8	Security Camera For Pkg Lot	2002	1,087		20	155	155	479	8
9	Security Camera For Rear Door	2002	744		20	106	106	328	9
10	Call Pad	2002	1,099		20	110	110	357	10
11	Concrete Steps	2002	2,620		20	262	262	939	11
12	Ejector Pump	2002	1,078		20	108	108	422	12
13	Hallway P.A.System	2002	3,774		20	377	377	1,510	13
14	Elevator	2002	5,862		20	293	293	1,075	14
15	Smoke Detector/Ceiling	2002	1,409		20	141	141	446	15
16	Tiles	2002	1,035		20	104	104	354	16
17	Delivery Security Camera	2003	1,858		20	93	93	232	17
18	Front Door Security Camera	2003	1,858		20	93	93	240	18
19	Condensing Unit	2003	7,825		20	652	652	1,576	19
20	A/C Compressor Circuit	2003	1,370		20	114	114	276	20
21	Piston Packing & Installation	2003	600		20	30	30	68	21
22	Thermostat & Actuator Control	2003	1,037		20	52	52	156	22
23	Connect Air Handler To Fire Alarm	2003	781		20	39	39	101	23
24	Service On Pa System & Monitor System	2003	738		20	37	37	92	24
25	Repair Cooling Coil & Air Handler	2003	3,992		20	200	200	566	25
26	Freezer Stat Controls	2003	940		20	47	47	133	26
27	Faucets	2004	5,750		20	575	575	910	27
28	Door Hardware	2004	2,429		20	243	243	385	28
29	Door Hardware	2004	1,147		20	115	115	172	29
30	Waiting Room	2004	30,517		20	3,052	3,052	4,577	30
31	Water Heater	2004	3,785		20	315	315	368	31
32	Door Detector	2004	1,892		20	95	95	150	32
33	Pump Motor	2004	3,137		20	157	157	170	33
34	TOTAL (lines 1 thru 33)		$ 3,549,601	$ 203,879		$ 139,327	$ (64,552)	$ 2,197,438	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,549,601	$ 203,879		$ 139,327	$ (64,552)	$ 2,197,438	1
2	Valve Tamper Panel	2004	5,693		20	1,139	1,139	1,328	2
3	Elevator Repair	2004	2,500		20	438	438	438	3
4	Monitor System Repair	2004	852		20	78	78	78	4
5	Monitor System Repair	2004	706		20	65	65	65	5
6	Kitchen Air Handler	2004	804		20	70	70	70	6
7	Chiller Repair	2004	668		20	47	47	47	7
8	Electrical Work	2004	2,731		20	171	171	171	8
9	Fire Alarm Repair	2004	596		20	32	32	32	9
10	Kitchen Doors	2004	775		20	78	78	78	10
11	Paint	2004	634		20	55	55	55	11
12	Locks	2004	1,586		20	119	119	119	12
13	Door Locks	2004	837		20	84	84	84	13
14	Door Locks	2004	419		20	84	84	84	14
15	Boiler Tubs	2005	13,800		20	958	958	958	15
16	Retube	2005	5,300		20	331	331	331	16
17	Fence Repair	2005	1,550		20	78	78	78	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,052	$ 203,879		$ 143,154	$ (60,725)	$ 2,201,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1986	1968	$ 1,899,326	$ 8,879	35	$ 54,266	$ 45,387	$ 1,757,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Removal Of Cove Base, Ceilings, Closet Walls, Frames & Drywall		2004	169,742	54,317	20	8,487	(45,830)	16,974	9	
10	Installment Of Carpet, Border, & Cove Base In 1st, 2nd & 3rd Floo		2004	89,574	28,664	20	4,479	(24,185)	8,957	10	
11	Handrails, Bumper Guards & Corner Guards in 1st & 2nd Floors		2004	21,852	6,993	20	1,093	(5,900)	2,185	11	
12	Light Fixtures, Floor Prep, Vinyl Tile In 1st Floor Dining Room		2004	23,145	7,406	20	1,157	(6,249)	2,315	12	
13	Cubicle Tracks & Corner Guards		2004	8,419	2,694	20	421	(2,273)	842	13	
14	Repainting, Ceiling Trimming, Crown Molding In Corridor		2004	42,081	13,466	20	2,104	(11,362)	4,208	14	
15	Custom Installation of VCT & Cove Base		2004	51,661	16,531	20	2,583	(13,948)	5,166	15	
16	Drapery Panels & Curtains In 2nd Floor Resident Rooms		2004	16,860	5,395	20	843	(4,552)	1,686	16	
17	Repainting, Ceiling Trimming, Crown Molding On 2nd Floor		2004	38,520	12,326	20	1,926	(10,400)	3,852	17	
18	Blinds & Mount Fixture		2004	3,706	1,186	20	185	(1,001)	371	18	
19	Crown Molding In Resident Rooms & Nurses Station		2004	19,078	6,105	20	954	(5,151)	1,908	19	
20	Replacing Drywall & Removal Of VCT In Therapy Room		2004	40,399	12,928	20	2,020	(10,908)	4,040	20	
21	Furnish & Install Of Light Fixtures In Corridor		2004	9,605	3,073	20	480	(2,593)	961	21	
22	Bathroom Remodeling		2005	1,925	43	20	96	54	96	22	
23	Gluedown Carpet In Conf. Room		2005	980	22	20	49	27	49	23	
24	Laminating Desk In Reception Area		2005	8,016	177	20	401	223	401	24	
25	Crown Molding		2005	1,183	26	20	59	33	59	25	
26	Wall Covering		2005	2,044	45	20	102	57	102	26	
27	Light Fixtures		2005	643	14	20	32	18	32	27	
28	Drapery Panels		2005	1,340	30	20	67	37	67	28	
29	Removal & Installation Of Vinyl In Lobby		2005	12,547	278	20	627	350	627	29	
30	Crown Molding & Wood Fronts In Nurses Station		2005	19,159	424	20	958	534	958	30	
31	Installation Of New Carpet & Cove Base		2005	892	20	20	45	25	45	31	
32	Faux Wood Blinds		2005	283	6	20	14	8	14	32	
33	Installation Of New VCT And Cove Base		2005	258	6	20	13	7	13	33	
34	Ceramic Tile Installation In Bathroom		2005	816	18	20	41	23	41	34	
35	Pedimat & Ceramic Tile In Vestibule		2005	3,829	85	20	191	107	191	35	
36	Wall Covering & Repainting In Med Room		2005	5,630	125	20	282	157	282	36	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Vestibule	2005	$ 204,998	$ 4,538	20	$ 10,250	$ 5,711	$ 10,250	37
38	Bumpers, Corner Guards & Handrails	2005	3,998	89	20	200	111	200	38
39	Door Casings	2005	1,463	32	20	73	41	73	39
40	Elevator Wraps	2005	930	21	20	46	26	46	40
41	Resident Room Pvc Sheeting	2005	3,882	86	20	194	108	194	41
42	Bumpers, Corner Guards & Handrails	2005	2,442	54	20	122	68	122	42
43	Drywall & Framing For Sprinkler Piping	2005	1,872	41	20	94	52	94	43
44	Time & Materials For Invoice Period	2005	309	7	20	15	9	15	44
45	Demolition Of Medication & Linen Rooms	2005	3,453	76	20	173	96	173	45
46	Electrical For Receptacles & Lights	2005	2,129	47	20	106	59	106	46
47	Concrete Flatwork	2005	978	22	20	49	27	49	47
48	Sliding Doors	2005	7,654	169	20	383	213	383	48
49	Installation Of New Window Opening	2005	3,039	67	20	152	85	152	49
50	HVAC, Sprinkler, Fire Alarm	2005	17,141	379	20	857	478	857	50
51	Fireproofing Of Existing Steel Beams	2005	403	9	20	20	11	20	51
52	New Ceilings & Lighting	2005	2,129	47	20	106	59	106	52
53	Cabinets, Countertops, & Plumbing	2005	1,093	24	20	55	30	55	53
54	New Shelving For DON Office Closet	2005	460	10	20	23	13	23	54
55	Plumbing	2005	1,496	33	20	75	42	75	55
56	Framing Of New Walls & New Doors	2005	(5,595)	(124)	20	(280)	(156)	(280)	56
57	Faux Food Blinds	2005	1,055	23	20	53	29	53	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,748,844	$ 186,935		$ 96,742	$ (90,193)	$ 1,826,399	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Mazel Mgmt		1985		$ 21,114	$	30	$ 704	$ 704	$ 14,252	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - ManagCare			1997	2,461	-	20	246	246	2,072	9
10	Allocation - ManagCare			1993	193	-	20	10	10	121	10
11	Allocation - ManagCare			1988	301	10	20	15	5	259	11
12	Allocation - ManagCare			1986	22,834	590	20	1,046	(456)	22,140	12
13											13
14	Allocation - Mazel Management			2005	498	71	20	24	(47)	24	14
15	Allocation - Mazel Management			2001	443	11	20	22	11	100	15
16	Allocation - Mazel Management			2000	224	6	20	11	5	59	16
17	Allocation - Mazel Management			1998	790	27	20	40	13	304	17
18	Allocation - Mazel Management			1997	737	19	20	37	18	307	18
19	Allocation - Mazel Management			1996	502	6	20	25	19	240	19
20	Allocation - Mazel Management			1995	114	3	20	6	3	60	20
21	Allocation - Mazel Management			1994	448	8	20	22	14	234	21
22	Allocation - Mazel Management			1993	265	8	20	13	5	165	22
23	Allocation - Mazel Management			1991	198	6	20	10	4	136	23
24	Allocation - Mazel Management			1990	308	6	20	15	9	237	24
25	Allocation - Mazel Management			1989	193	4	20	8	4	134	25
26	Allocation - Mazel Management			1987	438	9	20	-	(9)	438	26
27	Allocation - Mazel Management			1986	1,770	56	20	75	19	1,726	27
28	Allocation - Mazel Management			1985	123	-	20	-		123	28
29											29
30	Allocation - Inter Care Ltd.			2001	873	78	20	44	(34)	189	30
31											31
32											32
33											33
34											34
35											35
36											36

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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62									62
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 54,827	$ 918		$ 2,373	$ 543	$ 43,320	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 301,582	$ 14,801	$ 33,141	$ 18,340	10	$ 213,888	71
72	Current Year Purchases	15,205	7,283	1,260	(6,023)	10	1,260	72
73	Fully Depreciated Assets	132,775				10	132,730	73
74								74
75	TOTALS	$ 449,562	$ 22,084	$ 34,401	$ 12,317		$ 347,878	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation - ManagCare		2002	$ 40,813	$ 3,218	$ 7,119	$ 3,901	5	$ 18,885	76
77										77
78										78
79										79
80	TOTALS			$ 40,813	$ 3,218	$ 7,119	$ 3,901		$ 18,885	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,153,419	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,181	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,674	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,507)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,568,216	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 67,256	$		$ 67,256	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,150			11,150	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			63,919			63,919	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				77,779		77,779	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					35,479		35,479	12
13	Other (specify): See Supplemental						58,385		58,385	13
14	TOTAL			$		$ 142,325	$ 171,643		$ 313,968	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center **#** 0030551 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,482	$ 440,403	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	801,365	953,971	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,856	157,856	6
7	Other Prepaid Expenses	2,041	7,076	7
8	Accounts Receivable (owners or related parties)	9,000	472,184	8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,046,744	$ 2,034,490	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	598,660	598,660	15
16	Equipment, at Historical Cost	448,234	528,234	16
17	Accumulated Depreciation (book methods)	(597,536)	(2,994,201)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		6,413	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 449,358	$ 1,168,196	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,496,102	$ 3,202,686	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 614,714	$ 614,715	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,968	52,968	28
29	Short-Term Notes Payable	100,000	100,000	29
30	Accrued Salaries Payable	40,398	40,398	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,720	7,720	31
32	Accrued Real Estate Taxes(Sch.IX-B)		170,800	32
33	Accrued Interest Payable	57,213	89,995	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	513,064	9,209	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,386,077	$ 1,085,805	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,386,077	$ 5,085,805	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 110,025	$ (1,883,119)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,496,102	$ 3,202,686	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (190,535)	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	5,254	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (185,281)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	295,306	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 295,306	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 110,025	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,002,520	1
2	Discounts and Allowances for all Levels	(323,239)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,679,281	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	289,072	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 289,072	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,918	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,553	19
20	Radiology and X-Ray	1,145	20
21	Other Medical Services	53,312	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 140,928	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,712	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,712	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,648	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,648	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,113,641	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,099,705	31
32	Health Care	2,077,776	32
33	General Administration	1,602,638	33
	B. Capital Expense		
34	Ownership	549,053	34
	C. Ancillary Expense		
35	Special Cost Centers	410,870	35
36	Provider Participation Fee	78,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,818,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	295,306	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 295,306	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,812	2,125	$ 70,005	$ 32.94	1
2	Assistant Director of Nursing	472	480	16,710	34.81	2
3	Registered Nurses	15,548	16,114	420,576	26.10	3
4	Licensed Practical Nurses	22,978	24,581	499,056	20.30	4
5	CNAs & Orderlies	56,960	62,361	572,643	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,946	7,705	77,451	10.05	8
9	Activity Director	3,783	4,263	34,233	8.03	9
10	Activity Assistants	5,136	5,526	40,676	7.36	10
11	Social Service Workers	6,524	7,165	93,896	13.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,497	20,543	196,856	9.58	15
16	Dishwashers					16
17	Maintenance Workers	2,310	2,578	27,286	10.58	17
18	Housekeepers	23,176	25,481	233,653	9.17	18
19	Laundry	8,784	9,816	79,841	8.13	19
20	Administrator	2,111	2,206	92,495	41.93	20
21	Assistant Administrator	2,080	2,080	82,288	39.56	21
22	Other Administrative	594	594	48,471	81.60	22
23	Office Manager					23
24	Clerical	10,598	11,509	163,708	14.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,921	2,149	24,204	11.26	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,570	2,570	96,902	37.71	33
34	TOTAL (lines 1 - 33)	192,800	209,846	$ 2,870,950 *	$ 13.68	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	104	$ 4,856	01-03	35
36	Medical Director	Monthly	17,100	09-03	36
37	Medical Records Consultant	80	3,520	10-03	37
38	Nurse Consultant	46	3,935	10-03	38
39	Pharmacist Consultant	Monthly	5,098	10-03	39
40	Physical Therapy Consultant	58	5,089	10a-03	40
41	Occupational Therapy Consultant	32	1,674	10a-03	41
42	Respiratory Therapy Consultant	1	18	10a-03	42
43	Speech Therapy Consultant	2	87	10a-03	43
44	Activity Consultant	38	1,955	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	361	$ 43,332		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	23	$ 1,251	10-03	50
51	Licensed Practical Nurses	2,276	76,544	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,299	$ 77,795		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miron Tabic (1/1/05 - 2/1/05)	Administrator	0	$ 7,044
Moshe Davis (2/1/05 - 12/31/05)	Administrator	0	85,451
Yehoshua Davis	Operations	0	33,470
Nesanel Davis	Asst Admin	0	82,288
Yosef Davis	Administrative	72.34	15,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 223,253

B. Administrative - Other

Description	Amount
Management Fees - InterCare, Ltd	$ 82,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 82,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Econocare	Purchasing Consultant	$ 2,538
S&K Medical Center	Quality Assurance	12,000
Jahwed Ehsan	Administrative Consultant	2,664
Personnel Planners	Unemployment Tax Cons	4,927
Honkamp	Unemployment Tax Cons	60
American Data	Computer Services	4,902
Bryan Varquez	Computer Services	100
KIPP Computer Solutions	Computer Services	10,200
Myers, Miller & Krauskopf	Legal	13,845
Winston & Strawn	Legal	736
Center for Disab. & Elder Law	Legal	500
See Supplemetal Schedule		234,438
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 286,910

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,682
Unemployment Compensation Insurance	36,426
FICA Taxes	212,866
Employee Health Insurance	117,041
Employee Meals	13,761
Illinois Municipal Retirement Fund (IMRF)*	
City Payroll Tax	5,176
Employee Benefits	1,679
Holiday Expense	5,957
Employee Pension	2,731
Disability Insurance	3,235
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,554

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 912
Advertising: Employee Recruitment	20,660
Health Care Worker Background Check	750
(Indicate # of checks performed 75)	
Licenses and Permits	2,453
Dues and Subscriptions	6,260
Annual Fee	643
Advertising and Promotion	33,992
Allocate ManagCare	1,956
See Supplemental Schedule	57
Less: Public Relations Expense	( )
Non-allowable advertising	(33,992)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,691

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,381
Allocate ManagCare	210
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,591

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $7,743**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,023** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **78,293**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,761** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.